

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

74 County Madaway Registration District No. 628  
9 Township Park Primary Registration District No. 3031  
7 City Maryville Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward \_\_\_\_\_)

File No. 40888  
Registered No. 114

2. FULL NAME Frank Smith

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mary Smith</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>1856-1847</u>		
7. AGE YEARS <u>76 85</u>	MONTHS	DAYS
If LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>None</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Boone Co. Mo</u>		
13. NAME <u>Unknown</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
15. MAIDEN NAME <u>Chaney</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
17. INFORMANT (ADDRESS) <u>Mrs. Mary Smith Maryville Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Oak Hill Cem.</u> DATE <u>12-16</u> 19 <u>32</u>		
19. UNDERTAKER (ADDRESS) <u>Campbell Funeral Home Maryville Mo</u>		
20. FILED <u>12-15</u> 19 <u>32</u> <u>Mamie G. Clardy</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 14<sup>th</sup> 1932

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at 3:20 pm.

The principal cause of death and related causes of importance were as follows:

95B  
167 Similarity  
Acute Cardiac Decomensation  
Other contributory causes of importance:  
95B  
95B

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? no Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) W. R. Jackson, M. D.

(Address) Physician Bldg.

Maryville Mo.

